STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
21 GRAND STREET HARTFORD, CT 06106-1500
Toll-Free 1-800-504-1102 (860) 241-8400 Fax (860) 525-6018 www.ct.gov/trb

TRB SPONSORED MEDICARE SUPPLEMENTAL INSURANCE INFORMATION

The Connecticut Teachers' Retirement Board sponsors the following plans:

1) Medicare Supplement with Prescriptions
2) Medicare Supplement with Prescriptions and Dental Coverage
3) Medicare Supplement with Prescriptions and Dental, Vision & Hearing Coverage

Please refer to the **Health & Prescription Drugs Plan Benefits Summary** for specific coverage information.

Enrollment Requirements

All coverage takes effect on the 1st day of the month. Enrollment forms must be received by the 25th day of the second month preceding the effective date of coverage. For example, for coverage to become effective as of December 1st, the form must be received by October 25th. The premium will be deducted from the benefit payment dated November 30th.

If you are a new retiree or the spouse of a new retiree, coverage can begin no earlier than two months after the effective date of your retirement. A July retiree would obtain coverage effective September 1.

Complete one application per enrollee. An enrolling member and a spouse must each complete a separate enrollment form. Submit proof of Medicare eligibility either by a photocopy of your Medicare Card or a letter from the Social Security Administration stating the Medicare Claim # and the effective date of coverage.

Cancellations

A written cancellation request must be received by the 25th day of the second month preceding the effective date of termination of coverage. To terminate coverage May 1st, notification must be received by March 25th. You will not be allowed to re-enroll in any of the TRB Sponsored Plans until the next open enrollment period.

Coverage Changes

Once you enroll in a health plan through TRB, you must remain in that plan until the next open enrollment period of January 2005.

Prescriptions

An annual $250.00 deductible is required for all members of the plan. The Mail Order Pharmacy co-pays are 15% for generic drugs, 20% for preferred drugs and 30% for non-preferred drugs. The Retail Pharmacy co-pays are 20% for generic drugs, 25% for preferred drugs and 35% for non-preferred drugs. The deductible and co-pay amounts apply to pharmacy as well as mail order prescriptions. The maximum annual out of pocket cost is $1,000 per calendar year. Once you have reached this limit, the plan will pay the full cost of prescriptions for the balance of the calendar year.

Claims/Coverage

Hospital and Medical Claims are administered by the Board's Claim Administrator, Stirling & Stirling. Prescription Drug Benefits are administered by Paid Prescriptions - Medco Health. Dental Benefits are administered through the Delta Dental Plan of New Jersey. For questions regarding enrollment or claims, contact Teachers' Retirement Board at 1-800-504-1102 ext. 8414 or (860) 241-8414.

When filing claims, please be aware that retirees and spouses enrolled in any of our plans have individual coverage. All claims should be filed as "SELF" with your own social security number regardless of whether you are the retiree or the spouse.

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MEDICARE SUPPLEMENTAL HEALTH INSURANCE ENROLLMENT FORM

- Medicare must be your primary health plan.
- A PHOTOCOPY OF YOUR MEDICARE CARD or a letter from the Social Security Administration stating the Medicare Claim # and effective date of coverage is required for each enrollee.
- ONE ENROLLMENT FORM PER ENROLLEE must be received by the 25th day of the second month preceding the effective date of coverage.
- Once you enroll in a plan, you may not make any changes until the next open enrollment period.

I ELECT TO HAVE THE FOLLOWING COVERAGE BECOME EFFECTIVE: _____/**01**/_____
MONTH YEAR

CTRB Sponsored Health Plan Coverage Type	**Cost per month (per individual)**	**Check One (X)**
Medicare Supplement with Prescriptions	$51.00	☐
Medicare Supplement with Prescriptions and Dental	$84.00	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$88.00	☐
Cancel all TRB Coverage		☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name	First	Initial	Home Phone

Street Address	City	State	Zip Code

Enrollee's Social Security Number	Medicare Number	Date of Birth

Enrollee's Signature	Date	Email Address

If you are enrolling as the <u>spouse</u> of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number

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Street Address	City	State	Zip Code

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Enrollee's Signature	Date	Email Address

If you are enrolling as the <u>spouse</u> of a retired teacher, please furnish the following:

Retired Teacher's Name	Social Security Number